FOR OFFICE USE ONLY

Basic Health™

NOTE: *Please use blue or black ink to complete this application.*
Questions? Call 1-800-826-2444

You cannot add anyone in your family at this time unless they are printed above.

DO NOT SEND MONEY WITH THIS APPLICATION. ANY INCREASE IN PREMIUM WILL BE ADDED TO YOUR BILL.

FAMILY INFORMATION

Your street address (not a P.O. Box): ______________________

Mailing address or P.O. Box, if different from above: ______________________

Home phone number: (   ) ______________ Daytime or message phone number: (   ) ______________

	When listing names, please list the last name, then first name and middle initial.	U.S. citizen or legally admitted?	Requesting coverage?
ADULTS	Your name: ______ Sex: ❑ Male ❑ Female Social security number* ______ Birth date (mm/dd/yy) ______ ❑ Single ❑ Separated ❑ Married Date of marriage: ______	U.S. citizen or legally admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival: ______	❑ Yes ❑ No
	Spouse's name: ______ Sex: ❑ Male ❑ Female Social security number* ______ Birth date (mm/dd/yy) ______	U.S. citizen or legally admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival: ______	❑ Yes ❑ No
CHILDREN	Child's name: ______ Sex: ❑ Male ❑ Female Relationship to you: ______ Social security number* ______ Birth date (mm/dd/yy) ______ Full-time student? ❑ Yes ❑ No School: ______	U.S. citizen or legally admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival: ______	❑ Yes ❑ No
	Child's name: ______ Sex: ❑ Male ❑ Female Relationship to you: ______ Social security number* ______ Birth date (mm/dd/yy) ______ Full-time student? ❑ Yes ❑ No School: ______	U.S. citizen or legally admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival: ______	❑ Yes ❑ No
	Child's name: ______ Sex: ❑ Male ❑ Female Relationship to you: ______ Social security number* ______ Birth date (mm/dd/yy) ______ Full-time student? ❑ Yes ❑ No School: ______	U.S. citizen or legally admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival: ______	❑ Yes ❑ No
	Child's name: ______ Sex: ❑ Male ❑ Female Relationship to you: ______ Social security number* ______ Birth date (mm/dd/yy) ______ Full-time student? ❑ Yes ❑ No School: ______	U.S. citizen or legally admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival: ______	❑ Yes ❑ No
	Is anyone in your family who is applying for coverage pregnant? ❑ Yes ❑ No If yes, attach proof that shows pregnant woman's name and due date. Due date: ______ Provider's name ______ Phone number ______		

*You do not need to have a social security number (SSN) to enroll in Basic Health. If you do have a SSN, you do not have to give it to us. However, if you give us your SSN, it will help us determine your eligibility.

VOLUNTARY INFORMATION

Completing this section is voluntary and will not affect your ability to enroll, but may help us to better assist you.

Ethnic Background

- ❑ Black/African-American
- ❑ White/Caucasian
- ❑ Asian or Pacific Islander (API) Specify: _____
- ❑ Hispanic/Latin American Specify: _____
- ❑ Other or mixed ethnic background Specify: _____

Primary language spoken: _____

Did you receive help with completing this application? If so, from whom?

- ❑ Family/friend
- ❑ Local, nonprofit organization
- ❑ Medical office/hospital/clinic
- ❑ Government office, such as DSHS or your local health department
- ❑ Write in the name of the organization or clinic that helped you with this application: _____

Agreement and Signature

I understand that:

- I must send proof of my gross family income (before taxes) and report income changes that would change my premium or eligibility to Basic Health within 30 days after the end of the month that the new income was earned. My signature on this form authorizes Basic Health to verify my family income with other state or federal income reporting agencies.
- I must report address changes and changes in my family, for example, a marriage or divorce, the birth of a child, or a child who leaves the home or is no longer a dependent or full-time student.
- Basic Health may check information — through contact with other state or federal agencies — about my family's income, Washington State residency, eligibility for Medicare, and any other information needed to verify my eligibility for enrollment in Basic Health.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am not eligible for coverage.

I authorize any health plan or medical provider to give Basic Health medical records for myself or my children under age 18 that are necessary for purposes of my participation in Basic Health.

I authorize DSHS to share with Basic Health information used to determine my eligibility for Medical Assistance programs, to assist in determining my eligibility for Basic Health.

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application and attachments is true, correct, and complete to the best of my knowledge. I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under Basic Health or additional premium amounts due, and may face other penalties for prosecution and collection.

AGREEMENT MUST BE SIGNED BY APPLICANT AND SPOUSE

X _____	_____	X _____	_____
Signature of applicant	Date	Signature of spouse	Date

Signature of all others age 18 or over applying for coverage

X _____	_____	X _____	_____
Signature	Date	Signature	Date

Washington State law may require disclosure of any information you submit as a public record.
The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling 360-923-2822.

Please enclose this application and any required documentation in the envelope provided.
Mail to Basic Health, P.O. Box 42683, Olympia, WA 98504-2683

Si desea ayuda en español, llame al 1-800-321-0291. Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.
한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오. Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.